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CHAPTER VII
SURGERY: URINARY, MALE GENITAL,
FEMALE GENITAL, MATERNITY CARE
AND DELIVERY SYSTEMS
CPT CODES 50000 -59999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter VII
Surgery: Urinary, Male Genital,
Female Genital, Maternity Care
and Delivery Systems
CPT Codes 50000 - 59999

A. Introduction

The general policies previously promulgated regarding CPT defined services apply to the urinary tract. Because of the contiguous nature of the urinary tract, and the accessibility of the urinary tract to endoscopic intervention, several specific issues require emphasis.

B. Urinary System

1. Many procedures involving the female and male urinary system include the placement of a urethral catheter for postoperative drainage. Because this is integral to the service and represents the standard of medical practice, placement of a urinary catheter is not separately coded. In addition, catheterizations (e.g. CPT codes 51701, 51702, and 51703) are not separately reported when done at the time of or just prior to a surgical procedure.

2. Many lesions of the genitourinary tract which require biopsy, excision or destruction involve the mucocutaneous border and several CPT codes may generally describe the nature of the biopsy obtained. For a biopsy of a lesion or group of similar lesions, one unit of service for the CPT code that most accurately describes the service rendered is reported. As noted in the general policies, in Chapter I, when a biopsy is followed by an excision or destruction during the same session, only the most extensive service is reported. Additionally, separate codes (e.g. integumentary and genitourinary excision codes) are not to be reported unless the biopsy, excision, destruction, etc., service involves completely separate lesions; in these cases, the -59 modifier will indicate that separate lesions were removed. The medical record should reflect accurately the precise location of the lesions removed, particularly if it is medically necessary to submit each lesion as a separate specimen for pathological evaluation.

3. Policies regarding injections and infusions (e.g. HCPCS/CPT codes 36000, 36410, 90780 and 90781) as part of more extensive procedures have previously been defined and apply to the genitourinary family of codes. When irrigation procedures or

drainage procedures are necessary and are integral to successfully accomplish a genitourinary (or any other) procedure, only the more extensive service is reported.

4. Unless otherwise defined by *CPT Manual* instructions, the repair and closure of surgical procedures are included in the CPT code for the more extensive procedure and are not to be separately reported. In many genitourinary services, hernia repair is included in the *CPT Manual* descriptor for the service; accordingly, a hernia repair is not separately reported. If the hernia repair performed is at a different site, this can be separately reported with the -59 modifier indicating that this service occurred at a different site (i.e., via a different incision).

5. In general, multiple methods of accomplishing a procedure (e.g. prostatectomy) are not performed at the same session (see general policy on mutually exclusive services); therefore, only one method of accomplishing a given procedure can be reported. In the event that an initial approach is unsuccessful, and an alternative approach is undertaken, the approach which successfully accomplishes the procedure becomes the medically necessary service and is reported; if appropriate, a -22 modifier may be appended to the procedure code for the successful approach.

6. When an endoscopic procedure is performed as an integral part of an open procedure, only the open procedure is reported. If the endoscopy is confirmatory or is performed to assess the surgical field ("scout endoscopy"), the endoscopy does not represent a diagnostic or surgical endoscopy. The endoscopy represents exploration of the surgical field, and should not be separately reported under the diagnostic or surgical endoscopy codes. When an endoscopic procedure is attempted unsuccessfully and converted to an open procedure, only the open procedure is reported (see general policy on sequential procedures). If the endoscopy is performed for diagnostic purposes and a subsequent therapeutic service can be performed at the same session, the procedure is coded at the highest level of specificity. If the *CPT Manual* narrative includes endoscopy, then the diagnostic endoscopy is not separately coded. If the narrative does not include endoscopy and a separate endoscopy is necessary as a diagnostic procedure, this can be reported separately. The -58 modifier may be used to indicate that the diagnostic endoscopy and the subsequent therapeutic service are staged or planned procedures. The medical record must describe the intent and findings of the diagnostic endoscopy in these cases.

7. When multiple endoscopic procedures are performed at the same session, the most comprehensive code accurately describing the service performed is reported; if several procedures are performed at the same endoscopic session, the -51 modifier is attached. (For example, if a renal endoscopy is performed through an established nephrostomy, a biopsy is performed, a lesion is fulgurated and a foreign body (calculus) is removed, the appropriate CPT coding would be CPT codes 50557 and 50561-51, not CPT codes 50551, 50555, 50557, and 50561.) This policy applies to endoscopic procedures in general and specifically to endoscopic procedures of the genitourinary system.

8. When bladder irrigation is performed as part of a more comprehensive procedure, or in order to accomplish access or visualization of the urinary system, the bladder irrigation (CPT code 51700) is not to be reported. This code is to be used for irrigation with therapeutic agents or for irrigation as an independent therapeutic service.

9. When electromyography (EMG) is performed as part of a biofeedback session, neither CPT code 51784 nor 51785 is to be reported unless a significant, separately identifiable diagnostic EMG service is provided. If either the CPT code 51784 or the CPT code 51785 is to be used for a diagnostic electromyogram, a separate report must be available in the medical record to indicate this service was performed for diagnostic purposes.

10. When endoscopic visualization of the urinary system involves several regions (e.g. kidney, renal pelvis, calyx, and ureter), the appropriate CPT code is defined by the approach (e.g. nephrostomy, pyelostomy, ureterostomy, etc.) as indicated in the CPT descriptor. When multiple endoscopic approaches are simultaneously necessary to accomplish a medically necessary service (e.g. renal endoscopy through a nephrostomy and cystourethroscopy performed at the same session), they may be separately coded with the multiple procedure modifier -51 on the less extensive codes. When multiple endoscopic approaches are necessary to accomplish the same procedure, the successful endoscopic approach should be reported.

11. When urethral catheterization or urethral dilation (e.g. CPT codes 51701-51703) is necessary to accomplish a more extensive procedure, the urethral catheterization/dilation is not to be separately reported.

12. Multiple ureteral anastomosis procedures are defined by CPT codes 50740-50810, and 50860. In general, they represent mutually exclusive procedures and are not to be reported

together. If one anastomosis is performed on one ureter, and a different anastomosis is performed on a contralateral ureter, the appropriate modifier (e.g. -LT, -RT) is used with the appropriate CPT code to describe the service performed on the respective ureter.

13. CPT code 50860 (ureterostomy, transplantation of ureter to skin) is mutually exclusive of CPT codes 50800-50830 (e.g. ureterostomy, ureterocolon conduit, urinary undiversion) unless performed at different locations in which case an anatomic modifier should be used.

14. The CPT codes 53502-53515 describe urethral repair codes for urethral wounds or injuries (urethrorrhaphy). When a urethroplasty is performed, codes for urethrorrhaphy should not be reported in addition since "suture to repair wound or injury" is included in the urethroplasty service.

C. Male Genital System

1. Transurethral drainage of a prostatic abscess (e.g. CPT code 52700) is included in male transurethral prostatic procedures and is not reported separately.

2. Urethral catheterization (e.g. CPT codes 51701, 51702, and 51703), when medically necessary to successfully accomplish a procedure, should not be separately reported.

3. The puncture aspiration of a hydrocele (e.g. CPT code 55000) is included in services involving the tunica vaginalis and proximate anatomy (scrotum, vas deferens) and in inguinal hernia repairs.

4. A number of codes describe surgical procedures of a progressively more comprehensive nature or with different approaches to accomplish similar services. In general, these groups of codes are not to be reported together (see mutually exclusive policy). While a number of these groups of codes exist in CPT, a specific example includes the series of codes describing prostate procedures (CPT codes 55801-55845). In addition, all prostatectomy procedures (e.g. CPT codes 52601-52648 and 55801-55845) are also mutually exclusive of one another.

D. Female Genital System

1. When a pelvic examination is performed in conjunction with a gynecologic procedure, either as a necessary part of the procedure or as a confirmatory examination, the pelvic examination is not separately reported. A diagnostic pelvic examination may be performed for the purposes of deciding to perform a procedure; however, this examination is included in the evaluation and management service at the time the decision to perform the procedure is made.

2. All surgical laparoscopic, hysteroscopic or peritoneoscopic procedures include diagnostic procedures. Therefore, CPT code 49320 is included in 38120, 38570-38572, 43280, 43651-43653, 44200-44202, 44970, 47560-47570, 49321-49323, 49650-49651, 54690-54692, 55550, 58545-58554, 58660-58673, 60650; and 58555 is included in 58558-58563.

3. Lysis of adhesions (CPT code 58660) is not to be reported separately when done in conjunction with other surgical laparoscopic procedures.

4. Pelvic exam under anesthesia indicated by CPT code 57410, is included in all major and most minor gynecological procedures and is not to be reported separately. This procedure represents routine evaluation of the surgical field.

5. Dilation of vagina or cervix (CPT codes 57400 or 57800), when done in conjunction with vaginal approach procedures, is not to be reported separately unless the CPT code manual description states "without cervical dilation."

6. Administration of anesthesia, when necessary, is included in every surgical procedure code, when performed by the surgeon.

7. Colposcopy (CPT codes 56820, 57420, 57452) should not be reported separately when performed as a "scout" procedure to confirm the lesion or to assess the surgical field prior to a surgical procedure. A diagnostic colposcopy resulting in the decision to perform a non-colposcopic procedure may be reported with modifier -58. Diagnostic colposcopies (56820,57420,57452)are not separately reported with other colposcopic procedures.

E. Maternity Care and Delivery

The majority of procedures in this section (CPT codes 59000-59899) include only what is described by the code in the CPT definition. Additional procedures performed on the same day would be reported separately. The few exceptions to this rule consist of:

- CPT codes 59050 and 59051 (fetal monitoring during labor), 59300 (episiotomy) and 59414 (delivery of placenta) are included in CPT codes 59400 (routine obstetric care, vaginal delivery), 59409 (vaginal delivery only), 59410 (vaginal delivery and postpartum care), 59510 (routine obstetric care, cesarean delivery), 59514 (cesarean delivery only), 59515 (cesarean delivery and postpartum care), 59610 (routine obstetric care, vaginal delivery, after previous cesarean delivery), 59612 (vaginal delivery only after previous cesarean delivery), 59614 (vaginal delivery and postpartum care after previous cesarean delivery), 59618 (routine obstetric care, cesarean delivery, after previous cesarean delivery), 59620 (cesarean delivery only after previous cesarean delivery), and 59622 (cesarean delivery and postpartum care after previous cesarean delivery). They are not to be separately reported.
- The total obstetrical packages (e.g. CPT codes 59400 and 59510) include antepartum care, the delivery, and postpartum care. They do not include among other services, ultrasound, amniocentesis, special screening tests for genetic conditions, visits for unrelated conditions (incidental to pregnancy) or additional and frequent visits due to high risk conditions.

F. General Policy Statements

1. Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475 and 90780 describe services that may be utilized for postoperative pain management. The services described by these codes may be reported only if performed for purposes unrelated to the postoperative pain management.

2. Medicare Anesthesia Rules prevent separate payment for anesthesia when provided by the physician performing a medical or surgical service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or intravenous infusion (CPT code 90780) should not be reported when these services are related to the delivery of an anesthetic agent.

